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Case Report

Incidental finding of bilateral lateral vaginal wall fibroid, in an antenatal patient during course of labor

Pooja Prajapati*, Kirti Prajapati

Department of Obstetrics and Gynaecology, Laxmi Narayan Medical College and Research Center, J. K. Hospitals, Bhopal, Madhya Pradesh, India

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***Correspondence:**
Dr. Pooja Prajapati,
E-mail: poojaprajapati106@gmail.com

ABSTRACT

Vaginal leiomyomas remain an uncommon entity with only about 300 reported cases since the first detected case back in 1733 by Denys de Leyden. We report a case of 25-year-old G2P1L1 (Previous FTNVD), who presented inpatient department with c/o 10 months amenorrhea with lower abdominal pain for one day. On general physical examination, no pallor, no Jaundice, no edema and vitals were stable. On per abdominal examination 1-2 uterine contraction for 10 second in 10 min was observed. On per vaginal examination internal OS was 2 cm dilated, 20-30% effaced, vertex at-3, medium consistency, mid position, membrane intact and pelvis adequate noted. She was admitted in labor room and kept watched for spontaneous progression of normal labor. After 6 h of admission, she started having adequate uterine contractions 2-3 for 30 sec in 10 min. On PV examination she was 6 cm dilated with 60-70% effaced, vertex at -1, soft consistency, anterior position. Artificial rupture of membrane was done. Liquor was clear. Inj oxytocin in drip was started at 8 drops/min. During vaginal examination, A firm sessile, painless mass with smooth surface of size 1×1 cm was felt on both right and left vaginal wall which suggestive of vaginal leiomyoma grossly. During course of labor, progression of labor was halted during second stage of labor. Inj oxytocin drop rate increased at 32 drops/min to achieve adequate uterine contraction. A male baby of 2.8 kg was delivered in stable condition. Right mediolateral episiotomy was repaired with rapid vicryl suture 2,0. Patient was informed and vaginal fibroid finding was mentioned on discharge summary. Patient was called after 6 weeks for follow-up.

Keywords: Vaginal fibroid, Leiomyoma, Labor

INTRODUCTION

Vaginal tumors are rare and include papilloma, hemangioma, mucus polyp, and rarely leiomyoma. Vaginal leiomyomas remain an uncommon entity with only about 300 reported cases since the first detected case back in 1733 by Denys de Leyden.[1] Vaginal leiomyomas are commonly seen in the age group ranging from 35 to 50 years and are reported to be more common among Caucasian women.[2]

CASE REPORT

We report a case of 25-year-old G2P1L1 (Previous FTNVD), who presented inpatient department with c/o 10 months amenorrhea with lower abdominal pain for one day. On general physical examination, no pallor, no jaundice, no edema and vitals were stable. On per abdominal examination 1-2 uterine contraction for 10 second in 10 min was observed.

On per vaginal examination internal os was 2 cm dilated, 20-30% effaced, vertex at -3, medium consistency, mid position, membrane intact and pelvis adequate noted (Bishop's score-3).

She was admitted in labor room and kept watched for progression of normal labor. After 6 hours of admission, she was started having adequate 3-4 uterine contractions lasting for 30 sec in 10-minute duration.

On PV examination she was 6 cm dilated with 60-70% effaced, vertex at -1, soft consistency, anterior position (Bishop's score-11). Artificial rupture of membrane was done. Liquor was clear. Inj oxytocin in drip was started at 8 drops/min.

During vaginal examination, A firm, sessile, painless mass with smooth surface of about size 1×1 cm was felt on both right and left vaginal wall which was suggestive of vaginal leiomyoma on gross examination.

In our case, patient was unbooked at our center. No previous prescription showed. Patient wasn't informed about vaginal fibroid before. No previously diagnosed vaginal fibroid during her antenatal visits.

During course of labor, progression of labor was halted during second stage of labor. Inj oxytocin drop rates increased at 32 drops/min to achieve adequate uterine contraction.

A male baby of 2.8 kg was delivered in stable condition. Right mediolateral episiotomy was repaired. Patient was informed and mentioned on discharge summary about vaginal fibroid and left in situ.

Patient was called after 6 weeks for follow-up.

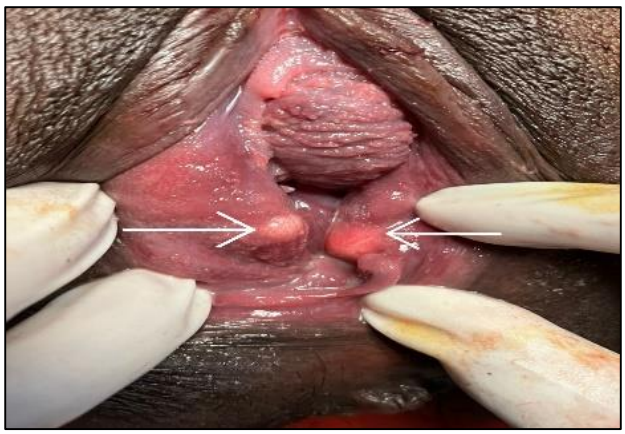

Figure 1: Bilateral lateral vaginal wall fibroid.

Shortcomings

Diagnosis was made on gross appearance. Histopathological examination couldn't be possible as enucleation of fibroid wasn't done in our case, due to sessile fibroid as complete enucleation could be difficult and also risk of hemorrhage due to increased vascularity in pregnancy. Another reason of being small size, as fibroid regresses itself after pregnancy in postpartum period.

DISCUSSION

The reported prevalence of fibroids in pregnancy is 10.7%.[1] This estimate could be low given that uterine fibroids may affect fertility. Fibroids necessitating surgery in pregnancy are rare, and myomectomy in pregnancy has been reported to be successful in a few series.[3,4]

Vaginal tumors arise most commonly from the anterior vaginal wall causing varied clinical presentations. They may or may not be associated with leiomyomas elsewhere in the body.

They usually occur as a single, well-circumscribed mass arising from the midline anterior wall and less commonly, from the posterior and lateral walls.[5,6]

These tumors can be intramural/ sessile or pedunculated and solid as well as cystic. Usually, these tumors are single, benign, and slow-growing, but sarcomatous transformation has been reported.[7]

They may be asymptomatic but may give rise to cyclic urinary retention, dyspareunia, gluteal swellings with vaginal purulent discharge, obstruction in the birth passage if along with pregnancy, or simply a feeling of mass in vagina.[8,9]

Surgical removal of the tumor through a vaginal approach, preferably with urethral catheterization to protect the urethra during surgery, is usually the treatment of choice.[8]

In the case of large tumors, however, an abdominoperineal approach is preferred. Histopathological confirmation is the gold standard of diagnosis and also beneficial to rule out any possible focus of malignancy.[8]

CONCLUSION

Vaginal fibroids are rare. Determining the origin, site and size of vaginal fibroid prior to labor is important for accurate preoperative and postoperative plan of management with patient and further counselling.

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